

Re-Entry Planning for Persons with Co-Occurring Disorders

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Objectives

- Understand the need to identify persons with cooccurring disorders through screening, assessment and in databases
- Identify essential elements of community based care for persons with COD
- Discuss issues related to continuity of care
- Become aware of the 'APIC' transition model
- ♦ Become familiar with the GAINS Re-entry Checklist
- Prioritize continuity of care between and among systems



What is 'Re-entry'?

Persons with co-occurring disorders 'cycle' through the criminal justice system, typically due to factors associated with the symptoms of their mental illness or substance use disorders

Many are arrested multiple times per year for things ranging from county ordinance violations to felony assault

Nearly everyone in jail – and prison – will re-enter the community

Of the 7 million people who are released yearly from local correctional facilities, approximately 6.4% of the men and 12.2% of the women have a severe mental illness (GAINS, 2001)



Why Break the Jail-Community-Jail Cycle?

◆ Costly – in officer time with re-arrests, court costs, legal costs, medications expense

 Costly – to individuals with symptom exacerbation, loss of housing, medication changes, escalation of charges



Defining Co-Occurring Disorders

"Co-occurring Disorders" is used instead of "dual diagnosis" because clients often have more than two disorders

Co-occurring Disorders typically defined as

- a) at least one substance disorder, plus
- b) at least one major mental disorder
 - -Major Depression -Bipolar Disorder
 - -Schizophrenia/psychotic disorders



Co-Occurring Disorders: Prevalence

National Co-Morbidity Survey (Kessler et al., 1994)

- Used representative national community sample
- 30% had 12 month history of at least one DSM-III-R diagnosis
- 52% of those with alcohol disorders at some point in their lifetime also had a history of at least one mental disorder



Co-Occurring Disorders: Prevalence

National Co-Morbidity Survey

- 59% of those with other drug disorders at some point in their lifetime also had a history of at least one mental disorder
- Of those with lifetime co-occurrence, 84% reported that their mental illness symptoms preceded their substance use disorder (Kessler et al., 1994)



Co-Occurring Disorders: Relapse Factors

The most common cause of mental illness relapse is substance abuse

The most common cause of substance abuse relapse is untreated mental illness (SAMHSA, 1997)



Level of Burden

The more difficulties you have, the more likely you are to appear for treatment

More 40% of persons with three or more disorders have **never received any treatment** (Kessler et al., 1994)



Screening & Assessment for Co-occurring Disorders

All clients should be screened for both mental health and substance use disorders

Screening for mental health and substance abuse problems should be completed at the earliest possible point after involvement in the treatment system



Key Points Regarding Screening for Co-occurring Disorders

Provide screening at different stages of treatment

Use similar or standardized screening instruments across different treatment settings

Information from prior screenings / assessments should be communicated across different points in the system



Screening and "Detection"

Simple Screening Instrument for AOD Abuse (SSI)

Number of Items: 16 on full version, 4 on short version Format: Self-Report and Clinician-Administered

Scales

- 1. Alcohol and Other Drug Use
- 2. Preoccupation and Loss of Control
- 3. Adverse Consequences
- 4. Problem Recognition
- 5. Tolerance and Withdrawal

Cost: Free; Author: Center for Substance Abuse Treatment

Source: Treatment Improvement Protocol (TIP) Series 11

Electronic version available online at http://www.health.org/govpubs/BKD143/



Screening and "Detection"

Mental Health Screening Form III

- •18 yes / no questions that inquire about previous history of mental health treatment / contacts; should be used as an interview method that can be inquired about re when did the problem begin, what was happening in your life at that time, did the problem begin before, during or after you were using substances?
- offers one screening question that addresses depression, PTSD, delusional disorder, gender identity disorder, manic episodes, panic disorder, obsessive /compulsive disorder, phobias, intermittent explosive disorder, eating disorders, pathological gambling, learning disorders / mental retardation.

Available from www.projectreturn.org; www.asapnys.org/resources/mhscreen.pdf



Twelve Steps in the Assessment Process (TIP42)

- Engage
- Identify collaterals
- ♦ Screen for COD
- Determine Quadrant
- Level of care
- Diagnosis
- Disabilities and Impairments
- Strengths and supports
- Cultural and linguistic needs
- Problem Domains
- Stage of Change
- ◆ Plan Treatment



Methods for Assessment

M.I.N.I. / M.I.N.I. Plus

Format: Structured interview intended to be administered by trained interviewers who do not have training in psychology or psychiatry

- Takes 15-20 minutes to administer
- Spanish version is available, computerized version is also available
- available on the internet at www.medical-outcomes.com at no charge for single use by clinicians / researchers



Methods for Assessment

Global Appraisal of Clinical Need (GAIN)

- •Format: Structured interview method that covers treatment arrangements, substance abuse, mental health, physical health, legal, environmental, and vocational issues.
- •Takes 15- 30 min to administer; 20 minutes to score
- •Cost: Proprietary tools of Chestnut Health Systems. Currently considered in development, it can be used for evaluation and research at the cost of \$1 under limited license.
- Available from: Chestnut Health Systems, Inc.

www.chestnut.org/li/gain



Modifying Data Collection

What capacity do you have for collecting more than one diagnosis?

Is there any current requirement to enter both a mental health and substance use disorder diagnosis?

What other relevant variables could you collect that would help to better identify persons served with COD?

Are contract providers collaborative on data entry, diagnosis?

When is diagnostic information entered? How often is this updated?



Treating Persons with COD: Six Guiding Principles (TIP 42)

- **♦** Recovery Perspective
- **♦** Multi-problem viewpoint
- Phased Approach
- **♦** Early focus on 'real-life' problems
- **♦** Look at cognitive and functional impairments
- **◆** Use support systems to maintain success



What is Integrated Care?

In this model, treatment of all of the person's disorders are considered simultaneously, in the same service setting, developed by and delivered by cross trained (MH and SA) staff.

Service delivery staff are completely engaged in the treatment planning for both categories of disorder. Service is typically delivered by a multidisciplinary treatment team which includes mental health and substance abuse professionals.

In this model "caregivers take responsibility for combining interventions into one coherent package" (Drake, April, 2001, pg 470).



"Integration" also means that the services that were traditionally delivered in a particular way — may have to be modified to accommodate the issues or different symptoms of a mental health (or a substance use disorder).

Examples include:

Teaching social skills to improve relationships, but also to help resist or avoid social situations that can lead to relapse

Modifying the pace, emotional tone, length, or features of the group process to better match a group member's pattern of symptom experience.



Integrated Dual Diagnosis Treatment:

CMHS / Dartmouth Psychiatric Research Center

Essential Elements of Evidence-based Practice

- Screening for COD?
- Screening for Stage of Change?
- Screening for Trauma?
- Complete Assessment for COD?
- Referral to ARNP/Psychiatry?
- Assertive Outreach?



Integrated Dual Diagnosis Treatment: CMHS / Dartmouth Psychiatric Research Center

Essential Elements of Evidence-based Practice

- •Motivational Intervention?
- •Integrated Treatment team?
- •Integrated Treatment Plan?
- •COD groups?
- •Trauma Groups?
- •Family Psychoeducation?



Integrated Dual Diagnosis Treatment: CMHS / Dartmouth Psychiatric Research Center

Essential Elements of Evidence-based Practice

- •Illness Management / Skill Building groups?
- •Vocational Intervention / Supported Employment?
- •Linkage to Housing?
- •Plan for continuity of care?



Examples of Treatment Manuals:

- Motivational Groups for Community Substance Abuse Programs (Ingersoll, Wagner, & Gharib, 2002)
- ◆ Group Treatment for Substance Abuse: A Stages of Change Therapy manual (Velasquez et al., 2001)
- ◆ Overcoming Addictions: Skills Training for People with Schizophrenia (Roberts, Shaner, & Eckman, 1999)
- ◆ Co-Occurring Disorders: A Treatment Manual from the Suncoast Practice and Research Collaborative; (Moore, Peters, Hills et al., 2001); available online
- Seeking Safety: A treatment manual for PTSD and Substance Abuse (Najavits, 2002)



Preparing for Re-Entry: Mental Health Care in Jails

- Emphasis on transition planning remains limited in many jails
- Constitutional requirement for minimum psychiatric care
- Recent court cases (Brad H.) have created new focus on discharge planning
- Some jurisdictions are focused on In-Reach efforts
- Others on Out-Reach efforts



Effective Transition Planning

Essential components of a comprehensive re-entry plan:

- Housing
- Entitlements
- Treatment

(Trauma, Mental Health, and Substance Abuse)

- Parenting support
- Case management

Need to emphasize linkage and follow up in the community



Involving Consumers in Transition Planning

What has kept them successfully engaged in treatment before?

• What mix of treatments gave them the greatest stability in the community?

♦ Who has been a source of support?

How have peer mentors been helpful in the past?



Consequences of Inadequate Transition Plans

Increases the likelihood of recidivism, compromising public safety

Likely contributes to:

- Increased psychiatric symptoms
- Increased substance relapse
- Hospitalization
- Homelessness
- Suicidality



The APIC Model (Osher, Steadman, & Barr, 2002)

Assess the inmate's clinical and social needs, and public safety risks

Plan for the treatment and services required to address the inmate's needs

Identify required community and correctional programs responsible for post-release services

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services



APIC: Model Development

- Multi-site studies of jail mental health programs (Steadman, McCarty, & Morrissey, 1989)
- Continuity of care guidelines (American Association of Community Psychiatrists, 2001)
- Psychiatric services in jails and prison task force report (American Psychiatric Association, 2000)



APIC Model

- Relies on a positive correctional –
 behavioral health partnership
- Requires a division of labor among the jail and community based services
- Results in a reduction of duplication of services



APIC Model

A Coordinating Committee representing major stakeholders can facilitate systems integration

- Goals of the process are
 - Improved communication
 - Goal setting
 - Assigning accountability
 - Reforming



GAINS Re-entry Checklist

- Builds on the APIC Model
- ♦ Developed for use in jail as part of transition planning procedure
- For use with inmates identified with mental and/or co-occurring substance use disorders
- Better to identify dedicated staff to this effort
- Four-copy form allows for distribution to the consumer, medical, mental health, and facility
- ◆ Tested in Montgomery County, MD and Rensselaer County, NY jails



Primary Domains: Re-entry Checklist

- Mental Health Services
- Psychotropic Meds
- Housing
- Substance Abuse Services
- Health Care / Benefits
- Income / Benefits
- Food / Clothing
- Transportation
- Other: referrals to other services, court dates



GAINS Re-entry Checklist

Availability of the Checklist:

From the National GAINS Center

1 800 311-GAINS

or by email to gains@prainc.com